American Recovery and Reinvestment Act (ARRA)-Funded
National Health Service Corps/State Loan Repayment Program
Primary Care Health Professional Application

Instructions for Submitting an Application

- The application filing period will run from December 14, 2009 through September 29, 2010 or until the funds are expended, whichever comes first.
- Before submitting an application, please speak with the Human Resources unit or Recruiter at your prospective site to ensure that they are willing to participate in the program with you.
- The current application form must be used for submission. The form title includes the current grant period. Please go to www.oshpd.ca.gov/HWDD/SLRP.html to access the most current application.
- The completed application package must include:
    - Personal Statements, Part D of the application;
    - Certification of Practice Site, Part G of the application;
    - A letter of recommendation from the practice site; and
    - Copy of current lender statements (dated within one month of application submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name, current balance, account number, and the mailing address of the lender.
    - Copy of current license or certification
- Mail application package to: OSHPD/HWDD
  ARRA-Funded State Loan Repayment Program
  400 R Street, Suite 330
  Sacramento, CA 95811
- **Awards will be issued on a first-come, first-serve basis for qualified applicants who submit a complete application packet. Please read application instructions very carefully.**
- Notification of award will be sent out within 4-6 weeks of the end of the application period.
- Make sure that your site has submitted a Certified Eligible Site Application. If you need a copy of the application, please go to www.oshpd.ca.gov/HWDD/SLRP.html.

If you have questions regarding the application or eligibility, please e-mail the Program Administrator via e-mail at SLRP@oshpd.ca.gov or via telephone at (916) 326-3700.

ARRA-Funded NHSC/State Loan Repayment Program
Primary Care Health Professional Application

2009/2010 Grant Period

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications will be accepted from December 14, 2009, through September 29, 2010 or until funds are expended, whichever comes first. Please note that this application is only good for the 2009/2010 ARRA-funded grant period.

PART A: PERSONAL INFORMATION

Applicant's Name: _____

Mailing Address: _____

City: _____ **County**: _____ **State**: _____ **Zip**: _____

Phone Numbers (provide at least 2): (____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

(____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

(____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

E-mail address (provide at least 1): _____ **Wk** ☐ **Personal** ☐

_____ **Wk** ☐ **Personal** ☐

Social Security Number: _____ **CA Drivers License/ID:** _____

Date of Birth: _____ **Gender:** **Male** ☐ **Female** ☐

Race/Ethnicity:

American Indian or Alaska Native ☐
Asian ☐
Black or African American ☐
Other* ☐
Hispanic or Latino ☐
Native Hawaiian or Other Pacific Islander ☐
White or Caucasian ☐

***Please specify:** _____

List languages you speak, read, and or write in addition to English (check all that apply):

1. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐
2. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐
3. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐

For Official Use Only:

Application Rec'd: _____ **Postmark Date:** _____ **Reviewed by:** _____

Application: **Complete** ☐ **Incomplete** ☐ **Ineligible** ☐ **Applicant cleared by:** **NHSC** ☐ **HPEF** ☐

Practice Site: **On File** ☐ **Site Type:** **330** ☐ **RHC** ☐ **FQHC/LAL** ☐ **CHC** ☐ **County Clinic** ☐

Other: _____

MSSA Type: **Urban** ☐ **Rural** ☐ **Frontier** ☐ **State Region:** **Northern** ☐ **Central** ☐ **Southern** ☐

PC ☐ **MH** ☐ **DC** ☐ **HPSA ID #** _____ **HPSA Score** _____ **AD** ☐

PC ☐ **MH** ☐ **DC** ☐ **HPSA ID #** _____ **HPSA Score** _____ **AD** ☐

Comments:

PART B: QUALIFICATIONS AND ELIGIBLITY

1. **Are you a United States citizen?** Yes ☐ No ☐
2. **Do you have a current and unrestricted California license to practice your profession?** Yes ☐ No ☐
3. **Do you owe an existing service obligation to another entity?** Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)
4. **Are you free of judgments arising from Federal debt?** Yes ☐ No ☐
   (If no, please provide explanation in your personal statements, Part D of this application)
5. **Are you delinquent with any court ordered child support?** Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)

PART C: HEALTH PROFESSION INFORMATION

MD ☐ **DO** ☐
(Indicate primary specialty)

- **Family Physician** ☐
- **General Internist** ☐
- **General Pediatrician** ☐
- **Obstetrician-Gynecologist** ☐
- **General Psychiatrist** ☐
- Gerontology ☐
- **Physician Assistant** ☐
- **Nurse Practitioner** ☐
- **Certified Nurse-Midwife** ☐
- **Dentist (D.D.S)** ☐
- **Dentist (D.M.D)** ☐
- **Dental Hygienist** ☐
- **Clinical/Counseling Psychologist** ☐
- **Licensed Clinical Social Worker** ☐
- **Mental Health Counselor** ☐
- **Licensed Professional Counselor** ☐
- **Marriage and Family Therapist** ☐
- **Psychiatric Nurse Specialist** ☐

School:_____ **Date of Graduation:** _____

City: _____ **State:** _____ **Zip:** _____

Postgraduate Training: _____ **Year Completed:** _____

Board Eligible: ☐ **Board Certified:** ☐ **California License Number:** _____

Certificate Number: _____

PART D: PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

1. **Describe the types of training or work experience you have had in a medical, dental, or mental health professional shortage area.**
2. **Describe any cultural competency training and/or life experience you may have (include number of units completed in college or CME).**
3. **Why do you want to participate in the NHSC/State Loan Repayment Program?**
4. **If applicable, explanations for questions answered in Part B of this application.**

Part E: QUESTIONNAIRE (optional)

1. **Where did you hear about California's NHSC/State Loan Repayment Program? (check all that apply)**
   - ☐ **Work (employer/co-worker)**
   - ☐ **State Loan Repayment Program Website**
   - ☐ **Other Website (please specify)** _____
   - ☐ **Organization or Affiliation (please specify)**_____
   - ☐ **Other Source (please specify)** _____
   - ☐ **Family member, Friend, or Acquaintance**
   - ☐ **NHSC Website**

2. **Where did you receive the California NHSC/State Loan Repayment Program application form?**
   - ☐ **Work (employer/co-worker)**
   - ☐ **State Loan Repayment Program Website**
   - ☐ **Other Source (please specify)** _____
   - ☐ **Family member, Friend, or Acquaintance**
   - ☐ **State Loan Repayment Program Office**

PART F: EDUCATIONAL DEBT REPORTING

DIRECTIONS:

- **List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be complete even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete and it will not be reviewed.**
- **You must submit evidence of the educational debts listed below. Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted.)**
- **Make sure that the Lender Address listed below corresponds with the address to which payments are sent to. This address must also appear on the lender statements you have included in your application packet.**

1. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

2. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

3. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

4. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

5. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

PART G: CERTIFICATION OF PRACTICE SITE (to be filled out by the practice site)

The completed form must bear an original ink signature and be returned with the provider's application. Photocopies and faxed copies of the completed form are not acceptable.

In addition to this form, please provide a letter of recommendation stating why this applicant is a good candidate for the State Loan Repayment Program.

PRACTICE SITE INFORMATION

Please list the actual street address of the practice setting(s) where the applicant is working, or has entered into an agreement to provide services, full-time 40 hrs/wk (including a minimum of 32 hours of direct patient care).

*** Practice Site:**_____ **Percentage of time:** _____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Practice Site Contact Person: _____

Title: _____ **Telephone Number:** (____) _____

*** Practice Site:**_____ **Percentage of time:** _____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Practice Site Contact Person: _____

Title: _____ **Telephone Number:** (____) _____

MEMORANDUM OF UNDERSTANDING (MOU) INFORMATION

Please provide the name of the clinic or parent agency that will enter into a memorandum of understanding with the Office of Statewide Health Planning and Development.

Clinic or Parent Agency:_____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Contact Person (person who will sign MOU):_____

Title: _____ **Telephone Number:** (_____) _____

I certify that the practice site or parent agency will pay the applicant prevailing wages and agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed $25,000 for the first two years of committed service.

I declare under penalty of perjury that these statements are true and correct.

Name:_____ **Title:** _____

Signature: _____ **Date:** _____

Telephone Number: (____) _____ **E-mail:** _____

PART H: APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum two years of full-time practice. I authorize representatives of the Office of Statewide Health Planning and Development to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application.

Signature: _____ **Date:** _____

Submission Check List:

- ☐ **Completed Application**
- ☐ **Personal Statements**
- ☐ **Certification of Practice Site**
- ☐ **Letter of Recommendation from Practice Site**
- ☐ **Educational Debt Reporting Form and Lender Statements**
- ☐ **Copy of Current License or Certification**

Submit application and required documents to:

OSHPD/HWDD
ARRA-Funded State Loan Repayment Program
400 R Street, Suite 330
Sacramento, CA 95811